CON Task Force Issue Brief

Hospice Services

Statement of the Issue

Should the establishment of a new hospice program continue to require CON approval?

Summary of Public Comments

The Task Force received comments from 10 organizations regarding regulation of the establishment of new hospice programs under the CON program. Those comments are summarized below:

Erwin Abrams, on behalf of the **Hospice Network of Maryland**, which represents all 30 hospices in Maryland urged the Task Force to recommend that the Commission take no action to alter the current CON process for hospice. The current system has been reviewed and approved by the Health Care Commission and State Legislature as recently as 2001 and 2003, respectively. As the staff and legislature found, the CON for hospice in Maryland has produced great benefits for the development of hospice care in the State. According to Abrams, altering the current CON process for hospice could have serious adverse consequences for the quality and availability of Hospice care in the State. The Hospice Network encourages the Task Force to review the Health Care Commission's report to the legislature on CON dated January 1, 2001. In that report, "the Commission recommend[ed] that the General Assembly maintain existing Certificate of Need regulation for new or expanded hospice services…." Other comments from the Hospice Network of Maryland are summarized below:

> The CON process for hospice was also recently affirmed by the legislature in the overwhelming passage of SB 732 during the 2003 legislative session. That legislation re-stated the General Assembly's intent that a Certificate of Need is required to establish or transfer a hospice program in this State. According to the Hospice Network, hospice care in Maryland has flourished under the existing regulatory structure. Hospice care in Maryland is a vibrant and far-reaching service, enjoying a stability that serves to enhance the availability and quality of care Marylanders enjoy at end-of-life. Most jurisdictions in the State are served by multiple hospice programs. Even in very remote and rural regions of the State, at least one community-based hospice program, and sometimes more, serves citizens in those areas. Overall, hospice utilization in the State compares favorably with national averages. Moreover, Maryland serves the third-highest percentage of African Americans (after South Carolina and Georgia) of all states reporting data as part of the National Hospice and Palliative Care Association's National Data Set.

More importantly, according to the Hospice Network, the CON process has protected the citizens of the State of Maryland from some of the worst excesses of unscrupulous hospice providers that were unmasked during Operation Restore Trust, the initiative launched by the Office of the Inspector General….study…concluded "It may be more than coincidental that the worst of the excesses uncovered by Operation Restore Trust were concentrated in states without CON regulations and the subsequent reduction in capacity and use was less pronounced in states with CON regulation…." Modifications to the CON process for hospice carry the risk of de-stabilizing this carefully developed and highly effective service network. Moreover, the prospect of any change in the current regulatory structure could not come at a more unpropitious time for many Maryland hospices. Hospices in Maryland are facing many challenges including the manner in which hospice care is reimbursed by Medicare, Medicaid, and private insurance companies, the skyrocketing cost of medications and other medical services, declining lengths of stay, and the availability of qualified and committed staff and volunteers. …

According to the Hospice Network, nearly 80% of hospice services in Maryland are reimbursed by Medicare. The Medicare hospice benefit is structured as all-inclusive, predetermined, daily payments for four levels of service. This risk-bearing payment system, based on a daily capitated rate, is coupled with a requirement that the hospice meet all of the patient's medical, psychosocial, spiritual, and personal needs related to the terminal illness. These predetermined daily payments have not increased relative to the dramatic growth in the cost of palliative care treatments, the much-discussed explosion in the cost of prescription medicine, or the need to compete in a tight labor market with the higher salaries demanded by a shrinking skilled medical labor pool.

Abrams further reports that hospices in Maryland also are caring for patients for periods of time that are too short for optimal care or financial stability. Medicare's capitated payment system assumes a bell curve with a significant majority of days in care at medium cost levels. In this way, high initial costs are amortized over longer payment periods. This is not the situation today….The most expensive hospice days, which have always been the first several and the last several, are now nearly half of all days. Care for patients so close to death is extremely costly….The effect is significant economic pressure for hospices committed to providing the highest quality of care to patients.

Those who care for hospice patients are unique. Because death and dying are not easy subjects for most Americans, most who enter the medical or social work fields do not think of hospice work as their career choice. Those who would chose hospice, therefore, represent a small percentage of a shrinking medical labor pool. The overall shortage of registered nurses in Maryland, declining enrollments in social work programs, plus the nature of hospice work itself, has led to a job market that is very competitive….The fact that death is not an easy subject for our culture is also reflected in the number of people in a community who are available to serve as hospice volunteers. For hospice, volunteers are essential members of the caregiving team. Both the grassroots origins of most non-profit hospice programs and Medicare's requirement that certified hospices train and use volunteers mean that it is essential that hospices successfully attract volunteers…

Today, according to Abrams, the vast majority of hospices in the State of Maryland are non-profit agencies. Most of these institutions grew out of community efforts to improve care of the dying for local residents. Because of increasing cost pressures, these hospices have come to rely upon the generosity of local donors for fundraising dollars. In some cases, charitable donations cover over 25% of a community hospice program's operational costs.

> According to MHCC data for 2003, only six hospices in the State can break even without significant fundraising efforts….
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> According to the Hospice Network, introducing increased economic "competition" in the provision of hospice services in Maryland by modifying or eliminating the Certificate of Need will mean the following: In addition to coping with the economic pressures imposed by a capitated reimbursement system and shorter lengths of stay, competing with other health care institutions for skilled staff, and with other charitable enterprises for fundraising dollars and volunteers, hospices will have to divert resources from providing care to the dying to compete with one another. This additional burden could have serious consequences for quality hospice care. Increased competition will mean that hospices that have developed under Maryland's existing regulatory structure could be faced with a number of adverse scenarios. Aggressive competitors who may be more concerned with cutting costs while sacrificing quality of care, to achieve short term financial gain will be able to enter selected markets. …..
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> In addition, according to the Hospice Network, since there is little or no market incentive for hospice providers to offer services in remote and sparsely populated parts of the state… any growth in hospice services is most likely to take place in communities where there is already intense competition. This will further dilute the resources available to the existing programs and could adversely impact their ability to provide high quality service…..
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> In summary the Hospice Network of Maryland appreciates the efforts of the Task Force to review the role of CON across the range of health care service s in the State. What is clear is that the current regulatory structure has enabled a stable, vibrant community of hospice providers to attend well to the needs of the terminally ill citizens of the State. The staff's work in 2000 and 2001 provide strong evidence for retaining current regulations. Nothing has occurred in the intervening four years to suggest that the regulatory structure should be changed or to blunt the adverse consequences of such a change. Because it is so acutely cognizant of these consequences and their potential effect of the availability and quality of hospice care available to the citizens of the State, the Hospice Network of Maryland urges the Task Force to recommend that the Commission retain the existing CON regulation for hospice care.

In its comments, **Southern Maryland Hospital Center** states that certain services which are now regulated by CON could be better regulated by the marketplace. One example is home health and hospice services, (emphasis in original) which do not require large capital expenditures and whose costs are well contained by third-party reimbursement. (SMHC is itself a provider of home health services via its affiliate Southern Maryland Home Health Services, Inc., but believes that protectionism is not a sufficient justification for CON regulation).

Hal Cohen, submitting comments on behalf of **Carefirst** said that hospice and home health services could be removed from the list of services to be reviewed with little or no harm to the public. Some of the staff and other resources now being devoted to review of obstetrics and these services could be freed up to address other issues. Carefirst believes that adding capacity for hospice services neither increases hospice rates nor generates inappropriate hospice use, and that home health agencies have negligible capital costs which cannot create excess capacity.

Community Hospices of Maryland supports the position of the Maryland Hospice Network that changes to the existing CON regulations would negatively impact the quality of hospice care for the following reasons:

- *Reduced spending on clinical services*: Allowing large, out-of-state for-profit providers to come into the Maryland market would require more resources be spent on marketing budgets to compete against these providers.
- *Economic impact*: Profits generated by out-of-state providers would be taken out of the state economy as these profits return to out-of-state corporations.
- *Impact on local providers*: Out-of-state hospice providers have a competitive advantage over local providers, as they are able to achieve large economies of scale based on their national census volume.
- *Staffing shortages*: As Maryland faces a nursing crisis, increasing the number of hospice providers means increased competition for these scarce human resources.
- *Payer balance shift*: If large skilled nursing facilities (SNFs) or continuing care retirement communities (CCRCs) are allowed to provide their own hospice services, the payer balance for hospice care will shift as these organizations provide care to their well insured residents, leaving under-funded and indigent coverage to other hospice providers. Non-profit providers rely on a balance of payer sources to offset losses from providing care to the under- or un-insured populations.
- *Community benefit*: Non-profit hospice programs serve the needs of the communities they serve, regardless of a patient's ability to pay. SNFs and CCRCs serving their own residents would not be providing any additional community benefit, since their patient populations are well funded through Medicare, Medicaid, and private insurance programs.
- *Competition for philanthropic support*: Non-profit health care providers rely on the support of donors to help cover the costs of expensive treatments and services above the Medicare, Medicaid, and commercial insurance reimbursements to ensure that the patients receive the best in palliative care.

The **Jewish Social Services Agency (JSSA**) requests that the Task Force recommend that the Commission maintain the current CON process for hospice. JSSA is a non-profit agency which has provided care to the community for over 111 years. Last year alone, JSSA provided health, mental health, employment, and other social services to over 12,000 clients in Maryland through four offices in Montgomery County. JSSA has offered hospice services since 1984 on a fully nonsectarian basis. …Non-profit agencies such as JSSA which operate relatively small but very comprehensive services go the extra mile in supporting families who are facing terminal illness and want to care for their loved ones at home. JSSA fundraises extensively to leverage Medicare, Medicaid and other insurance reimbursement so that hospice clients can have the high quality care they need as they struggle to support their children, spouses, and other family members at such a critical time. JSSA provides a host of ancillary services from Meals on Wheels to specialized counseling for children. According to JSSA, the CON process should be sustained for a number of reasons:

- If the CON process is not preserved, the State will be placing community hospices with long histories of top-notch quality, prompt responsiveness, and charitable support for poor clients in jeopardy. Outside agencies may come in, force small agencies such as JSSA out of business, and then leave when they realize hospice is not the profit center they counted on.

- Non-profit, community based hospices such as JSSA provide gem-like quality of care. We are rooted in the community and can mobilize volunteers, fundraising dollars, and are held accountable to careful Board oversight on quality of care and commitment. At the same time, they are JCAHO accredited and meet all State and Federal regulations.

- Local non-profit hospices like JSSA cannot commit extraordinary money to slick marketing campaigns. They are well known by all the local hospitals and referral sources and reserve precious dollars for patient and family care.

- Local no-profit hospices are already struggling with the shortage of qualified nurses and competition for charitable dollars. Allowing statewide outside hospices to come into this area would jeopardize the very existence of community based hospices which have superb reputations and equally importantly, are able to absorb patients in need.

- JSSA's hospice has very gifted nurses who are available 24 hours a day, 7 days a week, 365 days a year. When a family calls in the middle of the night, or on a Sunday, JSSA is able to make a home visit within a ½ hour. JSSA and other local non-profit hospices have proven they can do this.

- There is only a compelling need for competition if the quality of care is lacking, if the availability of service is a problem, and if the price of care is not competitive. In Montgomery County, none of these problems exist!

According to JSSA, maintaining the current CON process would prevent a situation that threatens to undermine the commitment and stability, indeed very survival, of the current high quality providers of hospice by opening the market to other companies who do not have the community knowledge or dedication proven by existing hospices.

Hospice of Charles County urges the Commission to maintain the existing CON process for hospice care. They believe the present CON system is a sound approach with adequate controls and argue that any attempts to tweak the process may weaken it and produce serious adverse consequences. The existing regulations have been time tested and have given Hospice of Charles County the legitimacy to provide quality patient care to anyone who qualifies for and seeks admission to hospice care within their geographic area. Furthermore, the benefits to patients and the families are remarkable and are provided at little or not cost to the patient and their family. Hospice of Charles County does not see how increased competition could improve upon this.

Hospice of Charles County is a well-established, respected community-based resource whose non-profit business model was created in 1983. Over the past 22 years, they have positioned themselves to meet the challenges and changing needs of the growing and increasingly diverse population they serve….. They believe open competition would undeniably cause confusion among patients, family caregivers, the medical community, and the general public. It may create unnecessary delays from doctors, discharge planners and others over which hospice care provider to send a referral, and impose a perceived need from patients and caregivers to shop around for the best service. Confusion, along with delayed decisions—which are further amplified by the strong desire by a patient to continue curative treatment—would exacerbate the late referrals we are already experiencing. Approximately 25% of the Hospice of Charles County current admissions die within seven days. They also fear that unscrupulous hospice providers may attempt to pick and choose which patients to admit based on diagnosis and severity of condition, type of insurance coverage, distance and profitability, as well as compete for donations and volunteers.

According to Hospice of Charles County, changing the existing CON may force every hospice to redirect already scarce patient care dollars to marketing expenditures and for increased salaries to retain or hire skilled nursing professionals—who are already in short supply. They rely on the generosity of the public to help cover the expenses for individuals who are without means and do not

qualify for Medicare, Medicaid, VA or have private insurance; therefore the competition may cause cut-backs in programs and services that dying patients and their survivors have come to depend on. As a non-profit, they struggle each year to be fiscally responsible and operate on a balanced budget. Increased competition may force them to radically change their business model and focus. A terminal diagnosis has the power to make a person especially vulnerable, and in the past individuals have found comfort in knowing that Hospice of Charles County was ready, willing, and able to five them the medical, emotional, and spiritual support they wanted and needed….We implore you to help us maintain the goodwill and confidence the general public has for Hospice of Charles County.

Comments made by **James A. Forsyth, Esq.** recommend that the home health and hospice agencies should not be CON-regulated. If CON regulation of home health and hospice continues, the program should include provisions exempting multi-facility providers of long term care services including assisted living, skilled nursing and a range of other services. Sound health planning and regulatory policy should not impose CON barriers to the provision of necessary services by the facility to its own residents in such integrated health systems.

Montgomery Hospice supports the current CON program in Maryland as it governs hospice care. They concur with the views expressed by the Hospice Network of Maryland and recommend that the Task Force make no changes to the current CON process for hospice care providers. Their jurisdiction, Montgomery County, is currently served by eight hospice providers. Residents of this community clearly have ample choice among providers under the current system. They fear that if the CON process were altered or done away with, for-profit hospice providers would rapidly enter the market, driving down quality of care as they sought aggressive growth and profits. Since hospices are mandated with providing extensive un-reimbursed services, such as bereavement care, they believe the temptation for "for-profit" companies to reduce or restrict services poses a very real threat to the community. In fact, one of the larger for-profit hospice providers, Odyssey Hospice, is already under investigation by the Department of Justice for this kind of behavior. Furthermore, the entry of new competitors harms Montgomery Hospice's Casey House. Casey House has cared for thousands of Maryland residents over the past six years. Montgomery Hospice has made a significant investment in inpatient hospice care, and the community deserves to have this jewel maintained.

Carroll Hospital Center (CHC) states that it has had recent experience in submitting CON projects to the MHCC and therefore feels its input is timely and relevant. First and foremost, CHC supports maintaining the existing CON requirements especially for acute care, home care, and hospice. The CON program ensures that providers demonstrate need for a particular service before putting it into place and overburdening the health care system in a particular area.

Andrew Solberg states that the Commission should consider eliminating CON coverage for home care and hospice. He has long been an advocate of eliminating CON for home care and hospice services. He does not believe that health care planners can project the need for a specific number of home care or hospice agencies when there is no limiting "bricks and mortar" that help define capacity. The capacity of any home care or hospice agency is only limited by available nursing staff or volunteers it can recruit. Over the years, the CON regulation has served only to impose a moratorium on new home care and hospice agencies. Solberg states that the Commission should consider why it regulates home care and hospice and continue to regulate it only if it can demonstrate that it can genuinely hold down cost or have some other demonstrable benefit. It should not regulate it if it will do what the office of Health Care Quality already does in licensure. According to Solberg, if the Commission continues to regulate home care and hospice, it should recognize that it is doing so for political reasons, and not include a methodology projecting need in the State Health Plan.

Background

- ***Overview of Hospice Agency Services***

According to the National Hospice and Palliative Care Organization (NHPCO), hospice focuses on caring, not curing and, in most cases, care is provided in the patient's home. Hospice care also is provided in freestanding hospice centers, hospitals, and nursing homes and other long-term care facilities.

Hospice care programs are licensed in Maryland as either general hospice programs or as limited hospice programs under Health-General Article §19-901. A *general* hospice care program is defined as "a coordinated, interdisciplinary program of hospice care services for meeting the special, physical, psychological, spiritual, and social needs of terminally ill individuals and their families by providing palliative and supportive medical, nursing and other health services through home or inpatient care during illness and bereavement to individuals who have no reasonable prospect of cure, as estimated by a physician, and to the families of those individuals." A general hospice care program may provide services in a home-based setting or in a variety of inpatient health care facilities. *Limited* hospice care programs provide palliative and supportive non-skilled services through a home-based hospice care program only, obtaining palliative and supportive medical, nursing and other health services by referral.

- ***Supply and Distribution of Hospice Services***

In 2003, there were 29 licensed hospice programs in Maryland, 26 of those are licensed as general hospices. The remaining 3 (Caroline Hospice Foundation, Talbot Hospice Foundation, and Hospice Caring) are limited hospice programs. According to annual 2003 Maryland Hospice Survey data, seven hospices have inpatient hospice units (up from four in 2000) in addition to providing home-based care. They are as follows: Hospice of Baltimore, Hospice of Frederick County, Hospice of the Chesapeake, Joseph Richey Hospice, Montgomery Hospice, Stella Maris Hospice, and Talbot Hospice Foundation.

In addition to these facilities dedicated to hospice care, many nursing homes, assisted living facilities, and hospitals make beds available on a case-by-case basis for respite care and complex pain or symptom management of hospice patients. Typically, the facility reaches a contractual agreement with licensed hospice programs to provide care in the inpatient setting.

Every Maryland jurisdiction is served by at least one hospice program. Hospices may serve clients in one or more jurisdictions depending on the terms of its CON approval, or for an older agency, its grandfathering in the 1980s.

The Appendix contains a series of statistical tables describing hospice programs.

Summary of Positions in Support of Alternative Regulatory Strategies

	Deregulate from CON Review	Maintain Existing CON Review
Need	●CON requirement for hospice does not address residential hospice programs; inpatient hospices are only regulated if they exceed the capital threshold. ● Hospice programs can expand capacity on an unregulated basis by adding staff. This largely eliminates potential for determining that new agencies are needed, biasing the regulatory process in favor of existing hospices. ●Hospice utilization is limited by the number of people facing death. The addition of new hospice programs will not, in and of itself, drive an increase in hospice utilization. There is no danger of unnecessary utilization of hospice services.	● Some states have seen unregulated market entry (except for licensure and Medicare certification) leading to proliferation of agencies and destabilization of service delivery for some period of time. ●Operation Restore Trust in 1997 found fraud in hospices enrolling nursing home patients and providing limited or no services. The worst of this fraudulent conduct was concentrated in states without CON. ● The current threshold requirement (250 cases) serves to approve additional hospice programs when needed.
Access	●Removal of the requirement for CON review would potentially increase access to hospice services by eliminating a barrier to the development of more programs. ●Enforcement of authorized service areas for hospices is difficult due to home-based nature of service delivery and reliance on self-reporting of data used in monitoring.	● No indication that Marylanders lack access to hospice care; all jurisdictions served by at least one hospice program. ● Removal of CON and resulting increase in for-profit hospices might result in “cherry picking” and thus restrict access for costly patients or those who are uninsured. ● Access may be restricted in remote and rural areas which would be less profitable.
Cost	●The addition of hospice programs would stimulate competition and could promote cost efficiencies. ● Larger for-profit providers could achieve economies of scale by providing services to more clients.	●Hospice is a fixed price service where increased competition will not affect price. 80% of hospice care is paid by Medicare. ●The current short ALOS stay in hospice makes the provision of care expensive (highest charges in first and final days); increased competition might exacerbate this problem. ●Adding more agencies would increase competition for scarce nursing and other staff resources as well as for volunteers. ●Adding more agencies would increase competition for limited charity dollars.
Quality	●Most hospice programs are Medicare certified and meet JCAHO certification requirements; though this certification is voluntary, increased competition would encourage participation. ●Quality oversight already done by OHCQ	●CON review provides an initial, threshold review to determine whether a prospective hospice provider has financial resources, clinical sophistication, to obtain Medicare certification once licensed, thereby preventing marginal providers from entering market. ● With increased competition, providers would have to divert funds to marketing rather than patient care thus potentially diluting quality.

Appendix

Table 1. Maryland Hospice Programs: 2003

Hospice Name	License Type	Reported Agency Organization	Inpatient Unit	Jurisdictions Authorized to Serve
Hospice of the Chesapeake	General	Freestanding	Yes	Anne Arundel Prince George's
Joseph Richey Hospice	General	Freestanding	Yes	Anne Arundel Baltimore City Baltimore County Harford Howard Prince George's Washington
St. Agnes Healthcare Hospice	General	Hospital/HH Based	No	Anne Arundel Baltimore City Baltimore County Howard
Seasons Hospice	General	Home Health Based	No	Anne Arundel Baltimore City Baltimore County Cecil Harford Howard
Harford Hospice	General	Freestanding	No	Baltimore City Baltimore County Cecil Harford
Hospice of Baltimore	General	Hospital Based	Yes	Anne Arundel Baltimore City Baltimore County Carroll Frederick Harford Howard Prince George's
Stella Maris	General	Hospital/Nursing Home Based	Yes	Anne Arundel Baltimore City Baltimore County Carroll Harford Montgomery
Heartland Hospice	General	Freestanding	No	Anne Arundel Baltimore City Baltimore County Harford Howard Montgomery Prince George's
Home Call Hospice	General	Freestanding	No	Anne Arundel Baltimore City Baltimore County Carroll Harford Howard Montgomery Prince George's

Community Hospices	General	Nursing Home Based	Yes	Anne Arundel Baltimore City Baltimore County Cecil Harford Howard Prince George's Montgomery
Caroline Hospice Foundation	Limited	Freestanding	No	Caroline
Chester River Home & Hospice	General	Home Health Based	No	Kent Queen Anne's
Hospice of Queen Anne's	General	Freestanding	No	Queen Anne's
Shore Home Care	General	Hospital Based	No	Caroline Talbot
Talbot Hospice Foundation	Limited	Freestanding	Yes	Talbot
Coastal Hospice	General	Freestanding	No	Dorchester Somerset Wicomico Worcester
Holy Cross Home Care/Hospice	General	Hospital/HH Based	No	Howard Montgomery Prince George's
Hospice Caring	Limited	Freestanding	No	Montgomery
Jewish Social Service Agency	General	Freestanding	No	Montgomery
Montgomery Hospice	General	Freestanding	Yes	Montgomery
Calvert Hospice	General	Freestanding	No	Calvert
Hospice of Charles County	General	Freestanding	No	Charles
Capital Hospice	General	Freestanding	No	Prince George's
Hospice of St. Mary's County	General	Hospital Based	No	St. Mary's
Hospice of Memorial Hospital & Medical Center	General	Hospital Based	No	Allegany
Carroll Hospice	General	Freestanding	No	Baltimore County Carroll Frederick
Hospice of Frederick County	General	Hospital Based	No	Frederick Montgomery
Hospice of Garrett County	General	Freestanding	No	Garrett
Hospice of Washington County	General	Freestanding	No	Washington

Source: Maryland Health Care Commission

Table 2. Statistical Profile of Maryland and U.S. Hospice Agencies: 2003

	National	Range of State Percentages				MD
Agencies Reporting	888	Mean	25th%	Median	75th%	31
Agency Type						
Freestanding	51%	**52%**	**37%**	**54%**	**67%**	50%
Hospital based	29%	**35%**	**20%**	**31%**	**49%**	20%
Home Health based	19%	**21%**	**13%**	**18%**	**28%**	20%
Nursing Home based	1%	**6%**	**0%**	**6%**	**9%**	10%
Profit Status						
For Profit	18%	**20%**	**10%**	**14%**	**23%**	13%
Not for Profit	76%	**80%**	**78%**	**83%**	**88%**	87%
Government	6%	**9%**	**5%**	**8%**	**11%**	
Location						
Urban	21%	**23%**	**13%**	**18%**	**32%**	20%
Rural	39%	**39%**	**23%**	**36%**	**53%**	27%
Mixed	40%	**45%**	**33%**	**44%**	**54%**	53%
Memberships						
State Association	94%	**93%**	**90%**	**97%**	**100%**	100%
NHPCO	88%	**93%**	**86%**	**100%**	**100%**	
NAHC	34%	**33%**	**23%**	**30%**	**42%**	
Certification						
Medicare	97%	**95%**	**96%**	**100%**	**100%**	87%
Accreditation						
Accredited	64%	**59%**	**42%**	**65%**	**73%**	73%
JCAHO	45%	**46%**	**33%**	**44%**	**63%**	63%
CHAP	10%	**18%**	**8%**	**17%**	**24%**	3%
State Programs	6%	**13%**	**5%**	**7%**	**17%**	7%
Other	3%	**12%**	**2%**	**5%**	**14%**	
Not Accredited	36%	**41%**	**27%**	**35%**	**58%**	27%
Inpatient Facilities						
Agencies w/ IP or Res	20%	**21%**	**13%**	**18%**	**32%**	23%

Source: Perforum

Table 3. Statistical Profile of Maryland and U.S. Hospice Patients: 2003

	Comparison Statistic	National	Range of State Averages				MD
	Agencies Reporting	890	Mean	25th%	Median	75th%	31
Length of Stay							
ALOS	Program Mean	55.6	54.6	47.4	52.6	60.1	49.4
MLOS	Program Mean	22.3	21.5	16.6	19.0	25.2	23.0
% Died <7 Days	Program %	32.0%	31.6%	28.9%	31.5%	34.1%	33.1%
% Died 180+ Days	Program %	6.3%	6.1%	4.8%	5.8%	6.8%	4.1%
Gender							
Female	Population %	56%	56%	54%	56%	58%	58%
Male	Population %	44%	44%	42%	44%	46%	42%
Age							
0-17	Population %	0.4%	0.4%	0.2%	0.4%	0.5%	0.3%
18-34	Population %	0.7%	0.8%	0.6%	0.7%	0.8%	0.6%
35-64	Population %	17%	18%	16%	17%	20%	21.0%
65-74	Population %	19%	19%	17%	19%	20%	18.0%
75-84	Population %	32%	32%	31%	32%	33%	31.0%
85+	Population %	31%	31%	27%	31%	34%	29.0%
Pediatrics - CDC definition age 0-24							
< 1	Population %	0.1%	0.1%	0.0%	0.1%	0.1%	
1-10	Population %	0.1%	0.1%	0.0%	0.1%	0.1%	
11-24	Population %	0%	0%	0%	0%	0%	
0-24	Population %	0.4%	0.3%	0.2%	0.3%	0.5%	0.0%
Ethnicity							
Hispanic/Latino	Population %	4.3%	2.5%	0.3%	0.7%	2.6%	0.7%
Race							
American Indian/Alaskan	Population %	0.3%	0.3%	0.1%	0.1%	0.2%	0.1%
African American	Population %	8.8%	8.4%	2.7%	8.2%	11.2%	18.9%
Asian/Hawaiian/Pac. Islander	Population %	0.9%	0.7%	0.2%	0.4%	0.8%	1.0%
White/Caucasian	Population %	86%	87%	83%	86%	93%	75.0%
Other	Population %	4.4%	3.3%	1.1%	2.6%	5.1%	4.7%
Location on Admission							
Home	Population %	56.4%	58.8%	47.9%	58.7%	66.5%	70.5%
Nursing Home	Population %	22.6%	22.0%	15.9%	21.1%	28.2%	18.6%
Hospice Unit	Population %	5.0%	4.7%	0.0%	3.2%	6.8%	4.9%
Hospital	Population %	8.6%	7.7%	2.7%	6.3%	11.1%	2.3%
Free-Standing	Population %	4.0%	4.1%	0.0%	2.7%	8.0%	0.9%
Residential Care	Population %	3.4%	2.9%	1.2%	2.1%	4.5%	2.9%
Location of Death							
Home	Population %	49.7%	53.4%	45.2%	54.3%	59.2%	66.2%
Nursing Home	Population %	23.0%	22.9%	16.0%	21.7%	27.6%	19.4%
Hospice Unit	Population %	7.4%	7.2%	0.4%	6.0%	11.4%	6.8%
Hospital	Population %	9.2%	8.0%	3.5%	7.4%	10.6%	3.5%

	Comparison Statistic	National	Range of State Averages				MD
	Agencies Reporting	890	**Mean**	**25th%**	**Median**	**75th%**	31
Free-Standing	Population %	7.2%	5.9%	0.2%	5.3%	8.4%	1.8%
Residential Care	Population %	3.6%	3.4%	1.4%	2.3%	4.0%	2.4%
Level of Care (Days)							
Routine	Population %	95.5%	95.9%	94.4%	96.4%	97.4%	94.1%
General Inpatient	Population %	3.4%	3.4%	2.3%	2.9%	4.2%	5.1%
Respite	Population %	0.2%	0.2%	0.1%	0.2%	0.3%	0.3%
Continuous	Population %	0.9%	0.6%	0.1%	0.3%	0.5%	0.5%
Patient Volumes							
Average Daily Census	Program Mean	55.5	86	41	59	97	52
Patients Served	Program Total	408	637	273	438	832	429
Patient Days	Program Total	19,857	31,696	14,760	21,349	36,675	19,394
Admissions	Program Total	382	707	282	528	788	339
Duplicated Admissions	Program Total	24	93	11	21	40	
Deaths	Program Total	307	478	214	348	615	342
Non-Death Discharges	Program % of Total	12.1%	12.0%	10.2%	12.1%	13.3%	13.5%
Total Referrals	Program Total	468	698	311	497	816	524
Conversion Rate	Program %	81%	80%	77%	80%	83%	72.0%
Diagnosis							
Admissions by Diagnosis							
Cancer	Population %	49.1%	51.4%	46.9%	51.8%	54.7%	55.4%
Heart	Population %	11.1%	10.5%	9.6%	10.4%	11.6%	9.5%
Dementia	Population %	9.7%	8.5%	7.5%	8.3%	9.5%	10.9%
Lung	Population %	6.8%	6.9%	5.6%	7.0%	7.8%	5.3%
Kidney	Population %	2.9%	2.8%	2.5%	2.7%	3.2%	2.7%
Liver	Population %	1.7%	1.6%	1.2%	1.6%	2.0%	1.2%
HIV	Population %	0.7%	0.5%	0.2%	0.4%	0.8%	1.6%
Stroke/Coma	Population %	4.2%	3.9%	2.8%	3.8%	4.7%	2.8%
Motorneuron	Population %	2.0%	2.0%	1.5%	2.0%	2.4%	2.4%
Debility Unspecified	Population %	7.6%	8.3%	6.4%	8.1%	9.3%	5.2%
Other	Population %	4.3%	4.3%	1.6%	2.9%	4.8%	2.9%

Source: Perforum

Table 4. Hospice Closures and Mergers: 1995 – 2005

Date	Action
March 1995	Northern Chesapeake acquired Harford Hospice.
April 1995	Merger between Hospice of Memorial Hospital of Cumberland and Sacred Heart Hospital approved with creation of Western Maryland Health System.
December 1996	VNA Hospice of Maryland acquired North Chesapeake Hospice.
January 1997	Caroline County Health Department closed its hospice.
April 1997	Hospice of Frederick County acquired Frederick Memorial Hospice.
June 1997	Hospice of Baltimore acquired Hospice of Howard County.
November 1997	VNA Hospice of Maryland acquired Hospice of Prince George's County.
January 1998	Shore Home Care approved to serve Caroline County.
August 1998	Mid Atlantic acquired Hospice of Maryland.
October 1998	Bay Area-VNA merger.
October 1998	VNA of Maryland acquired Sinai Hospice.
January 1999	Upper Chesapeake Home Care acquired St. Joseph Medical Center Hospice (and home health).
May 1999	Hospice Foundation of Prince George's County re-acquired Hospice of Prince George's from VNA of MD.
June 1999	Hospice of St. Mary's relinquished its license and was acquired by St. Mary's Hospital.
September 1999	MedStar/VNA acquired Arundel Hospice.
December 1999	Bon Secours Hospice (and home health) closed.
December 1999	Carroll County General Hospital acquired Carroll Hospice.
February 2000	Heartland Hospice Services (div HCR Manor Care, Ohio) acquired Med-Atlantic Hospice.
July 2000 (completed)	VNA, Inc. (VNA of DC, which had been a Medlantic affiliate) assumed operations and statewide authority of Helix Home Health and Hospice (beginning January 1999). Became known as MedStar/VNA.
August 2001	Hospice of the Chesapeake acquired "assets related to hospice operations" and "provider of choice" designation for Anne Arundel Medical Center (Arundel Hospice) from MedStar/VNA.
December 2001	Washington Home acquired MedStar/VNA Hospice. Became known as Community Hospices.
July 2001	Hospice of Suburban Maryland acquired Hospice of Prince George's. Name change to Capital Hospice in 2004.
July 2002	Johns Hopkins Home Hospice ceased operation of its hospice, but contracted with Community Hospices to provide hospice services to patients.
July 2003	Chester River Hospice acquired Kent Hospice Foundation.
December 2003	VNA of Maryland was acquired by Seasons Hospice.

Source: Maryland Health Care Commission